Eduardo Diaz, MD PA
5703 NW 7th Street, Miami, Fl 33126
Ph:(305) 267-3462 / fax:(305)267-3463

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name:_____
DOB:_____

The above named patient is being treated in our Medical Office. We have been informed that He/She was treated at your facility. Please send us the following information regarding treatment and care:

__**Medical Abstract History**
__**Laboratory Reports and Studies**
__**Vaccine Information**
__**Growth Charts**

I hereby authorize_____
to furnish the above mentioned facility any information, without restriction of any kind, from my medical record in your facility. This information is to be mailed, faxed or hand delivered to me personally.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization.

_____
Signature of Patient or Representative Relationship

_____
Date Witness